IMPLEMENTING HEALTH REFORM

Accountable Care Organizations

One new concept to come out of the health reform debate is the Accountable Care Organization (ACO). The concept builds off the idea of the patient-centered medical home and calls for primary care physicians, specialists, and hospitals to band together to provide high-quality care for patients. Under the ACO concept, payments would be linked to quality, and ACO providers would have the opportunity to share in any savings realized through better, more cost-effective care. Under the Affordable Care Act, Medicare will launch a shared savings program in 2012 to test the concept.

Dr. Lori Heim, president of the American Academy of Family Physicians, explains how these ACOs might work and what might drive their popularity.

Clinical Psychiatry News: The AAFP has spent a lot of time promoting the concept of the patient-centered medical home and the medical home neighborhood. Is an ACO the next logical step?

Dr. Heim: The ACO builds on the foundation of a medical home based in primary care. Both have the same goals for the patient: coordinated care that ensures a seamless transition from one service to another and one level of care to another.

The core of an ACO is effective primary care with a focus on prevention, early diagnosis, chronic disease management, and other services delivered through primary care practices. We believe that in order to be successful, ACOs will require a robust network of practices founded in primary care. They may involve other primary care practices, subspecialists, and in some cases hospitals. Envision the ACO as an expanding circle of health professionals with the patient and the patient's medical home in the center.

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DR. HEIM

The ACO concept requires that medical-home practices commit to performance improvement and publicly reported performance results. ACOs are a formalization of the medical home neighborhood, which is essential for a medical home to realize its full potential. Thus, an ACO may be the next logical step for physicians whose practices offer a mix of services; however, isolated rural practices will have more barriers to overcome to become members of an ACO.

CPN: What are the advantages and disadvantages of an ACO?

Dr. Heim: ACOs will improve information flow and communication. They will offer payment incentives designed to produce high-quality, patient-centered, efficient care. The problem areas are in aligning the financial incentives in a way that provides the best value to the patient.

Cost savings to support an ACO will come largely from reductions in three areas: inappropriate hospital admissions and readmissions, diagnostic testing and imaging, and subspecialist expenses.

One of the greatest challenges to implementing an ACO is managing the conflicts associated with the internal distribution of funds. So, while we're likely to see improved referral patterns and communication that will provide seamless, high-quality health care, we also are likely to see tension as health communities move away from competition and toward cooperation and collaboration.

CPN: In the future, will all physicians be part of an ACO?

Dr. Heim: Because this concept is so new, it's hard to say. Decisions on organizing the delivery system will be local. We're going to see considerable experimentation with different structural models, different financing models, and different approaches to sharing payment or system savings among all providers. The medical home is important because its performance can be quantified and compensated relative to the value it brings to the entire system.

The movement will likely begin in large and well-organized independent practice associations (IPAs), multispecialty groups, and integrated delivery systems. For efficiencies of scale, other physicians will first need to organize into groups that can assume performance risk (for quality and efficiency, not insurance risk) and contract with specialists, hospitals, and other providers to build out the ACO model that will be attractive to employers and insurers.

CPN: What do physicians need to do now if they want to experiment with the ACO idea?

Dr. Heim: The first step is to become a high-performing practice by implementing medical procedures, protocols, and services, as well as quality improvement systems. The second step is to think about how physicians' practices fit into a larger health care community to provide comprehensive, integrated care. Physicians need to know their options for organizing into groups to create or become a part of an ACO.

Hospitals are strategically buying primary care and subspecialty practices in markets where ACOs are most likely to form in order to maintain a flexible posture for the future. It is important for us to examine future contracts in light of potential shared savings for ACO and other payment models, whether we remain in private practice and negotiate contracts, or consider becoming salaried physicians. ■

Dr. Heim is also a hospitalist at Scotland Memorial Hospital in Laurinburg, N.C.

Most Uninsured Young Adults Will Get Coverage by 2014

BY JANE ANDERSON

Health reform could benefit young adults more than any other uninsured group, expanding coverage to almost all 13.7 million of them through a combination of insurance reforms, subsidies, and Medicaid expansion, according to a report from the Commonwealth Fund.

Provisions of the Affordable Care Act that extend coverage of young adults as dependents to age 26 years probably will cover about 1.2 million of that population by the end of 2011. Extending Medicaid eligibility could provide coverage to another 7.1 million young people, beginning in 2014,according to the report.

VITALS

Major Finding: About half of uninsured young adults will get health insurance coverage by 2014, and most others in that group will be eligible for premium subsidies under the new health insurance reform law, which may enable them to seek needed care and alleviate debt.

Data Source: Commonwealth Fund Survey of Young Adults, 2009.

Disclosures: None was reported.

Further, combining premium subsidies with opportunities to purchase coverage via a health insurance exchange will provide the remaining uninsured young adults—defined by the report as aged 19-29 years—a chance to obtain affordable coverage starting in 2014.

"The benefit of the Affordable Care Act of 2010 for young adults cannot be overstated," Sara Collins, Ph.D., lead author of the report, said at a press briefing. "The provisions have the potential to cover 13.7 million young adults," or the same number that were uninsured in 2008.

However, that figure probably underestimates the current number of uninsured young adults, since unemployment has risen dramatically in that population since 2008.

Health care costs represent a significant problem for this group, whether or not they are insured, according to the report. A total of 76% of uninsured young adults and 37% of those with insurance went without needed care in 2009 because of its cost, the report said. One-third of all uninsured young people and 46% of those both uninsured and with chronic health problems reported that their health declined because they delayed getting medical care.

In addition in 2009, 60% of young adults without insurance had trouble paying medical bills, compared with 27% of their insured peers, according to the report. Medical debt also is a problem, the report found, with 11.3 million young people paying off medical debt. Half of those had asked family for financial help, while 39% said they were unable to meet other financial obligations such as student loans because of their medical debt.

More than half of the 13.7 million uninsured young adults are in families with incomes that will make them newly eligible for Medicaid under the health care reform law. Another 30% are in families whose incomes will qualify them for health insurance premium subsidies so they will not have to spend more than 3%-8% of their income on health insurance premiums. And 12% live in families whose incomes will qualify them for health insurance–premium subsidies so they won't have to spend more than 9.5% of their income on premiums, the Commonwealth Fund study found.

Fewer than 1 million uninsured young adults are expected to have incomes too high to qualify for premium assistance, the study authors said.

Many of those who will become newly insured through the law's provisions probably will seek care from primary care physicians rather than getting free care from emergency departments, noted Dr. Collins, the Commonwealth Fund's vice president for affordable health insurance. This has the potential to help primary care physicians because "these people will be coming in with insurance cards" that will cover much of their care.

"A lot of people have been getting free care," she said. "Now, providers will be reimbursed for care."

It's not clear whether the new law will lead to a significant shortage of primary care physicians to care for the influx of patients, but Dr. Collins said that the law authorizes a significant increase in funding for community health centers, which could take up some of the slack.

The report, "Rite of Passage: Young Adults and the Affordable Care Act of 2010," was based on federal health insurance data and a national telephone survey of 2,002 young adults. It was funded by the Commonwealth Fund. ■